

FILED FEB 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4558

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>158</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>GREENE</u>				a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>SPRINGFIELD</u>				c. CITY (If outside corporate limits, write RURAL and give township) <u>SPRINGFIELD</u>			
c. LENGTH OF STAY (in this place) <u>20 Yrs.</u>				d. STREET ADDRESS (If rural, give location) <u>811 N. KANSAS</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>811 N. KANSAS</u>				e. STREET ADDRESS (If rural, give location) <u>811 N. KANSAS</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>BOLTON</u>		b. (Middle) <u>JOHN</u>		c. (Last) <u>KEMP</u>	
4. DATE OF DEATH		(Month) <u>FEB.</u>		(Day) <u>17</u>		(Year) <u>1949</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>OCT. 29, 1866</u>		9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MERCHANT</u>		11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>CLEO KEMP</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME <u>MRS. E. E. HILTON</u>		ADDRESS <u>WALNUT GROVE, MO.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hemorrhage, cerebral</u>				None	
		ANTECEDENT CAUSES					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				20 years	
		DUE TO (b) <u>Generalized arteriosclerosis</u>					
		DUE TO (c) <u>115AD</u>					
		II. OTHER SIGNIFICANT CONDITIONS					
		Conditions contributing to the death but not related to the disease or condition causing death. <u>Carcinoma prostate</u>				3 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 1940</u> , to <u>17 Feb. 1949</u> , that I last saw the deceased alive on <u>16 FEB. 1949</u> and that death occurred at <u>6:45 PM</u> from the causes and on the date stated above.							
23a. SIGNATURE <u>J. G. Sicheluff, M.D.</u>				23b. ADDRESS <u>609 Cherry Street</u>		23c. DATE SIGNED <u>2-18-49</u>	
24a. TIME OF DEATH (Specify)		24b. DATE <u>2-18-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>UNION HILL</u>		24d. LOCATION (City, town, or county) (State) <u>WEST PLAINS MO.</u>	
DATE REC'D BY LOCAL REG. <u>2-19-49</u>		REGISTRAR'S SIGNATURE <u>Mrs. Handley Wood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Klingner & Co.</u>		ADDRESS <u>Spfld. Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision. _____
Student Embalmer No. _____

Signed _____
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.